MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

12429

Reg. Dist. No. 251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Millington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mo.

Hospital, institution, or street address where death occurred: Valmatey Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Piney Neck

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles W. Ashley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: (Late) Agnes L. Ashley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4 1859

8. AGE: Years 86 Months 5 Days 16 If less than one day: hrs. min.

9. Birthplace: Piney Neck Kent Co. Md. (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business: oyster packing

FATHER — 12. Name: David Ashley

FATHER — 13. Birthplace: Piney Neck Kent Co. Md.

MOTHER — 14. Maiden name: Mary Crouch

MOTHER — 15. Birthplace: Piney Neck Kent Co. Md.

16. Informant: Mrs. Gilbert Ashley

Address: Rock Hall, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/23/45 (month) (day) (year)

Cemetery or crematory: Ashley + Crouch Burying ground

Location: Piney Neck, Rock Hall Md

18. Funeral director: Marion V. Williams

Address: Chestertown Maryland.

19. Dec 21 1945 (Date rec'd by registrar) Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1945, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1945 to Dec. 20 1945 and that I last saw him alive on Dec. 18 1945

	DURATION
Immediate cause of death: Pneumonia	4 days
Due to: Chr. Interstitial Nephritis	Several years
Due to: Chr. Myocarditis	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Merritt Price M. D. or other

Address: Millington Md. Date signed: 12/20/45

12430

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:
County: Kent
City or town: Rock Hall (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Rock Hall (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Joseph Vincent Blunt
3.(b) Social Security Number:

4. Sex: M.
5. Color or race: Wh.
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Hester Blunt
6.(c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.): Nov 27 1884

8. AGE: Years 61 Months 1 Days — If less than one day ...hrs. ...min.

9. Birthplace: Queen Ann's Co, Md. (Town, county, and state)
10. Usual occupation: watchman
11. Industry or business: Packing House
FATHER 12. Name: Benjamin Blunt
13. Birthplace: Queen Ann's Co.
MOTHER 14. Maiden name: Sally Walters
15. Birthplace: Queen Ann's Co. Md.
16. Informant: Mrs Mildred Whaland
Address: Rock Hall, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 30 1945 (month) (day) (year)
Cemetery or ~~crematory~~: Wesley Chapel
Location: Rock Hall Md.
18. Funeral director: Edgar L. Lane
Address: Church Hill Md
19 12/29 1945 (Date rec'd by registrar) S. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 1945, at 3:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-24 1945, to 12-27 1945
and that I last saw him alive on 12-27. 1945

Cause	DURATION
Immediate cause of death: Tumor of the brain; Malignant.	3 to 4 years
Due to: Chronic Endo-Myocarditis	
Due to: Asthma bronchial	

Other conditions: —
(Include pregnancy within 3 months of death)
Major findings of operations: — Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Albert A. Burgard M. D. ~~or other~~
Address: Rock Hall, Md. Date signed 12/27/45

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

12431

Reg. Diat. No. 500

1. PLACE OF DEATH:
County: Kent
City or town: Galena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Galena
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel Thomas Bramble

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 10, 1872

8. AGE: Years 73 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Kent, Md.
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name George T. Bramble
13. Birthplace Md.

MOTHER 14. Maiden name Mary M. Dillhunt
15. Birthplace Md.

16. Informant Robert Bramble
Address Galena Md.

17. Buried Date thereof Dec. 6 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Galena
Location Galena Md.

18. Funeral director Edward Sellman
Address Millington Md.

19. 12/6 1945 Elizabeth J. Mumford Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1945 at 9:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1941 to Dec 4 1945
and that I last saw him alive on Dec 4 1945

Immediate cause of death	DURATION
Pneumonia	6 days
Due to Hemiplegia	47 days
Due to Arteriosclerosis	Several years
Other conditions Chronic Interstitial Nephritis	"

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Murrell Price M. D. or other
Address Millington Md. Date signed Dec. 5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

12432

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
Kent and Queen Anne's
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: High Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Simons Calloway

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Calloway
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): 8-11-83

8. AGE:

Years	Months	Days	If less than one day
62	4	3	...hrs. ...min.

9. Birthplace: Bowers Beach, Delaware
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business:
FATHER 12. Name: Peter Calloway
13. Birthplace: Harrington, Delaware
MOTHER 14. Maiden name: Harriet Reed
15. Birthplace: Delaware
16. Informant: Hosp. Records
Address: Chestertown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/45 (month) (day) (year)
Cemetery or crematory: Hollyund County
Location: Harrington, Delaware
18. Funeral director: Marvin V. Williams
Address: Chestertown, Maryland.
19. Dec. 18, 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1945, at 4 o'clock P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-23 1945 to 12-16 1945
and that I last saw him alive on 12-15 1945

	DURATION
Immediate cause of death: Acute intestinal obstruction	1 day
Due to: Adeno carcinoma of transverse colon and adhesions	3 years?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Adeno carcinoma of transverse colon. Date of op. 12-15-45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. C. Dick, M.D. M. D. or other
Address: Chestertown, Md. Date signed: 12-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12433

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 2-14

1. PLACE OF DEATH:
County: Kent
City or town: Fairlee
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Colemans Corner.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Worton Rd Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bradford Clayton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	married

6.(b) Name of husband or wife: Anna.
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): April 7 - 1899

8. AGE: Years: 46 | Months: 8 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Colemans Worton Rd
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Edward Clayton
13. Birthplace: Kent Co

MOTHER
14. Maiden name: Nelie Moody.
15. Birthplace: Caroline Co. Md

16. Informant: Howard Hynes
Address: Worton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24 1945 (month) (day) (year)

Cemetery or crematory:
Location: Colemans Worton R R

18. Funeral director: B R Fellows
Address: Still Pond Md

19. Dec 22 1945 (Date rec'd by registrar) F. M. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1945, at 1145 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from No Medical attention 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Apoplexy	3 hours
Due to: No history of any previous	
Due to: illness	
Other conditions: Died in P. Smith's Office	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work? No Accident

23. SIGNATURE: Frank M. Smith Kent Co M. D. or other
Address: Chestertown. Date signed: 12/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12434

Reg. Diat. No. 201

1. PLACE OF DEATH:

County Kent

City or town Norton 2nd Rural Colemans
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent

City or town Rural Norton, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Colemans
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miles Clayton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1894.

8. AGE: Years 51 Months 7 Days If less than one day hrs. min.

9. Birthplace Norton Md Colemans Rural
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

FATHER 12. Name Edward Clayton

FATHER 13. Birthplace Norton Md.

MOTHER 14. Maiden name Katie Moody.

MOTHER 15. Birthplace Caroline County

16. Informant Edward Clayton

Address Norton Md Rural,

17. Burial Date thereof Dec 28 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Colemans

Location Rural Colemans Norton Md

18. Funeral director B.R. Fellows,

Address Still Pond, Md.

19. 12 28 1945 J.H. Leach Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945 at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1943, to Dec 28 1945

and that I last saw him alive on Dec 23 1945

	DURATION
Immediate cause of death Chron. Endo-Card. Dis	
Decompensation	
Due to Parkinson's Syndrome	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert A Burgard M. D. or other

Address Rock Hall, Md. Date signed 12/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

12435

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred: 110 Cross St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Cross St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Frank Wenglenz (Cole)

3.(b) Social Security Number: 213-24-2293

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife: Elizabeth Sparks Cole

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): January 13 1894

8. AGE: Years 51 | Months 11 | Days 8 | If less than one day: hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: Electrician & Plumber

11. Industry or business: General

FATHER — 12. Name: Joseph Wenglenz

FATHER — 13. Birthplace: Prussia

MOTHER — 14. Maiden name: Unknown.

MOTHER — 15. Birthplace: ..

16. Informant: Mrs Elizabeth Cole (Wife)

Address: 110 Cross St. Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/45 (month) (day) (year)

Cemetery or crematory: Chester

Location: Chestertown Maryland

18. Funeral director: Marvin C. Williams

Address: Chestertown, Maryland.

19. Dec. 24 1945 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 21 1945 to Dec 21 1945 and that I last saw him alive on Dec 21 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. C. Simpers, M. D. or other

Address: Chestertown Date signed 12-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12436

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:
County: Kent
City or town: Rural Chestertown md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Rural Morgansec
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chestertown md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Michael Cotton

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widower

6.(b) Name of husband or wife: Minnie Cotton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 4th 1878

8. AGE: Years: 67 Months: Days: If less than one day: hrs. min.

9. Birthplace: Morgansec Rural Chestertown Kent md
(Town, county, and state)

10. Usual occupation: farm work

11. Industry or business: —

FATHER
12. Name: Isaac Cotton
13. Birthplace: Kent Co md

MOTHER
14. Maiden name: Miller
15. Birthplace: Kent md

16. Informant: Millie Cotton
Address: Rural Morgansec Chestertown md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 21/45 (month) (day) (year)

Cemetery or crematory: Morgansec
Location: Rural Chestertown md

19. Funeral director: B R Fellows
Address: Still Pond md

19. Dec 22 1945 (Date rec'd by registrar) J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1945, at 6 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
TB Medical Attention	
Due to for 1 year	
Due to Hemiplegia not Hypertension	1944
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at Work? .....

23. SIGNATURE: Frances Smith Nelson M. D. or other
Address: Chestertown Date signed: 12/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12437

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27)

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Kent

City or town: Betterton md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: Essex ave

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Betterton md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Essex ave
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Caldwell Howell Crew

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Francis Margaret Crew

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Aug 28 1869

8. AGE:

Years	Months	Days	If less than one day
76	3	18	...hrs. ...min.

9. Birthplace: Kent Co Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: —

FATHER
12. Name: Daniel Crew
13. Birthplace: England.

MOTHER
14. Maiden name: Amenda Blackpard
15. Birthplace: England.

16. Informant: Francis Margaret Crew
Address: Betterton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 13 1945 (month) (day) (year)

Cemetery or crematory: Still Pond

Location: Still Pond Md

18. Funeral director: B R Fellows

Address: Still Pond Md

19. Dec 13 1945 (Date rec'd by registrar) J M Elsbe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10 1945 at 2 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1 1945, to Dec 10 1945

and that I last saw him alive on Dec 10 1945

Immediate cause of death	DURATION
a Coma	1 day
Due to: Cortex sclerosis	2 y
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: H G Simpers M. D. or other

Address: Chestertown Date signed: 12/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12438

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

County Kent

City or town Worton Md Rural colemans
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent

City or town Rural Worton Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. Colemans
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Ford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27 1875

8. AGE: Years	Months	Days	If less than one day
70	1	21	hrs. min.

9. Birthplace Kent Co
(Town, county, and state)

10. Usual occupation Farm work

11. Industry or business

FATHER
12. Name John Ford
13. Birthplace Kent Co Md

MOTHER
14. Maiden name
15. Birthplace Kent Co Md

16. Informant Howard Ford

Address Kennedyville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 15 1945 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Still Pond Md

18. Funeral director B R Fellows

Address Still Pond Md

19. Dec 15 1945 J M Clark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14th 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Mr. Medical attendance	
Due to Died very suddenly.	
Due to Hypostatic Lung Congestion	1944
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank W. Smith M. D. Coroner

Address Chestertown. Date signed 12/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

12439

Reg. Diat. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A45

1. PLACE OF DEATH:

County: Kent

City or town: CHESTERTOWN Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: CAMPUS AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: KENT

City or town: CHESTERTOWN

(If outside city or town limits, write RURAL and give nearest town)

Street No.: CAMPUS AVE

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lillie Herbron Gary

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 9, 1866

8. AGE: Years	Months	Days	If less than one day
79	10	13	..... hrs. ..... min.

9. Birthplace: Kent Co. Maryland (Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER 12. Name: James H. Gary

13. Birthplace: Delaware

MOTHER 14. Maiden name: Mary Va. Price

15. Birthplace: Maryland

16. Informant: Mrs. Ernest Strong

Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1945 (month) (day) (year)

Cemetery or crematory: Still Pond Cem.

Location: Still Pond Maryland

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

18. Dec. 19, 1945 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 19 1945, at 9.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Dec 19 1945 and that I last saw h... alive on Dec 18 1945

Immediate cause of death	DURATION
Oedema of Lungs	1 day
Due to: Apoplexy	6 mo
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. G. Simpers, M. D. or other

Address: Chestertown Date signed: 12-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

CERTIFICATE OF DEATH

Reg. Dist. No. 2140 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Kent

City or town near Galena md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent

City or town Rural Galena md
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Galena
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jerry M Holden

3.(b) Social Security Number 220-12-4810

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25 1902

8. AGE:

Years	Months	Days	If less than one day
43	6	3	..... hrs. ..... min.

9. Birthplace Baltimore md
(Town, county, and state)

10. Usual occupation General work

11. Industry or business

FATHER 12. Name Jerry Holden

13. Birthplace Baltimore md

MOTHER 14. Maiden name

15. Birthplace Baltimore md

16. Informant Annie Wilmore

Address Fredrickton md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 26 1945 (month) (day) (year)

Cemetery or crematory Cecilton md

Location Cecilton md

18. Funeral director B & R Tolliver

Address Still Pond md

19. Dec 26 1945 (Date rec'd by registrar) Elizabeth J. Mulford Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Acute Alcoholism	
Due to Frozen Body from	
Due to Abright exposure	
Other conditions Chronic M.I. Battle Hd Wounds Epilepsy	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? No

23. SIGNATURE Frank W Smith Medical Admr
M. D. or other

Address Chestertown Date signed 12/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12441

Reg. Dist. No. 2102

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: 203 Water St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 203 Water St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: May Woodland Tuland

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

8.(b) Name of husband or wife: —

8.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 23 1868

8. AGE:

Years	Months	Days	If less than one day
77	7	23	____ hrs. ____ min.

9. Birthplace: Galena, Kent Co. Md.

(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Home

FATHER

12. Name: John Tuland

13. Birthplace: Galena Maryland

MOTHER

14. Maiden name: Mollie Comegys.

15. Birthplace: Galena Maryland

16. Informant: Mrs. John Herman Tuland

Address: Medford N. J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/20/45 (month) (day) (year)

Cemetery or ~~crematory~~: Shrewsbury

Location: Near Kennedyville Maryland

18. Funeral director: Manning W. Williams

Address: Chestertown, Maryland

19. Dec. 20, 1945 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 - 1945 at 3 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____ to ____ 19____ and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Found dead. Absent 2 days alone in house	
Due to:	
Coronary Vascular.	
Due to:	
Other conditions: Recently attacks, no medical person	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at Asylum Medical Advisor

23. SIGNATURE: Frank N. Smith M. D. or other

Address: Chestertown Md Date signed: 12/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-9)

12442

CERTIFICATE OF DEATH

★ Reg. Dist. No. 200

1. PLACE OF DEATH:

County: Kent

City or town: near Millington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: near Millington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George W Masten

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Emma Masten

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9 1892

8. AGE: Years: 53 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Wilbur Masten

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: Anna May Wolfe

MOTHER — 15. Birthplace: Delaware

16. Informant: Mrs Emma Masten

Address: Rural, Galena Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 16 1945 (month) (day) (year)

Cemetery or crematory: Galena

Location: Galena Md.

18. Funeral director: Edward Fellows

Address: Millington Md.

19. Dec. 11 1945 (Date rec'd by registrar) Edward Fellows Registrar

Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 7th 1945, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 1945 to Dec 7 1945 and that I last saw h alive on Dec 2d 1945

Immediate cause of death	DURATION
Apoplexy	
Due to: Hypertension	3 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G. L. Copeland M. D. or other

Address: Millington Md. Date signed: Dec 12 45

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

12443

Reg. Dist. No. 203

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: Eastern Neck

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Eastern Neck
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Milton L. Maslin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary E. Maslin

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 7 1864

8. AGE: Years	Months	Days	If less than one day
81	5	4	...hrs. ...min.

9. Birthplace: Kent Co, Md
(Town, county, and state)

10. Usual occupation: Farming (retired)

11. Industry or business: Self.

FATHER
12. Name: Francis Titus Maslin
13. Birthplace: Kent Co, Md

MOTHER
14. Maiden name: Mary Francis Vickers
15. Birthplace: Kent Co, Md

16. Informant: Mrs Mary Esseweiss
Address: Rock Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9 1945 (month) (day) (year)

Cemetery or ~~crematory~~: Wesley Chapel

Location: Rock Hall Md

18. Funeral director: Edgar L. Lane

Address: Church Hill Md

19. 12/8 (Date rec'd by registrar) 1945 Edward Bowen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6 1945, at 1130 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-26 1945, to 12-6 1945 and that I last saw h... alive on 12-5 1945

Immediate cause of death	DURATION
chron Endo-Myocarditis	
decompensation	
Due to	
Due to	
Other conditions: chron Colitis	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury — Injured at work? —

23. SIGNATURE: Albert A Burgard
M. D. or other

Address: Rock Hall, Md Date signed: 12/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 2021 12444

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown R.D 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No. near Flatland

(If rural give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Benjamin Franklin Quillen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: (Late) Clara Henry

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December 28, 1867

8. AGE:

Years	Months	Days	If less than one day
77	11	5	____ hrs. ____ min.

9. Birthplace: Dover Delaware (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER

12. Name: Isaac Quillen

13. Birthplace: County Cork, Ireland

MOTHER

14. Maiden name: Miriam Wood

15. Birthplace: Dover, Delaware

16. Informant: Mrs. Harry Irons (Daughter)

Address: Chestertown R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/5/45 (month) (day) (year)

Cemetery or crematory: Chesterfield

Location: Centreville, Maryland

18. Funeral director: Marvin V. Williams

Address: Chestertown, Maryland.

19. Dec. 5, 1945 (Date rec'd by registrar) Clara D. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1945, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30, 1945, to Dec. 1, 1945 and that I last saw him alive on Dec. 1, 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Lucas W. Smith M. D. or other

Address: Chestertown Date signed Dec 7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

12445

★ Reg. Diat. No. 201

1. PLACE OF DEATH:
County Kent
City or town Kennedyville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Kennedyville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ernest Linwood Pedrick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Married Brown Beadle
6.(c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) July 18. 1873

8. AGE: Years 72 | Months 7 | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace Kennedyville Md (town, county, and state)
10. Usual occupation Agricultural Implements
11. Industry or business Merchant

FATHER
12. Name Thomas Pedrick
13. Birthplace England

MOTHER
14. Maiden name Phillipina Silcox
15. Birthplace Delaware

16. Informant Mrs Linwood Pedrick
Address Kennedyville
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan (month) 1 (day) 1946 (year)
Cemetery or crematory Chester
Location Chestertown Md
18. Funeral director B R Fallows
Address Still Pond Md
19. 1-2 1946 J M Cloak
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1945 at 11.15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death No Medical Attended	
Due to Accident	
Due to Cerebral Hemorrhage	4 hours
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work
Motor Vehicle Accident

23. SIGNATURE Frank M. Smith M. D. or other
Address Chestertown Md Date signed 1/30/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

12446 H. Dodd

Reg. Diat. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Harry Benge Simmons

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Anna Gehr Simmons

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): December 22 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	11	24		

9. Birthplace: Newark Delaware (Town, county, and state)

10. Usual occupation: Doctor

11. Industry or business: Medicine

FATHER — 12. Name: George W. Simmons

FATHER — 13. Birthplace: Eng. Delaware

MOTHER — 14. Maiden name: Mary Benge

MOTHER — 15. Birthplace: Cecil Co. Maryland

16. Informant: Mrs. H. Benge Simmons (Wife)

Address: Chestertown, Kent Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/19/45 (month) (day) (year)

Cemetery or crematory: Principio Methodist Cemetery

Location: Principio Furnace Cecil Co. Md.

18. Funeral director: Marvin V. Williams

Address: Chestertown Kent Co. Md.

19. Dec. 18, 1945 (Date rec'd by registrar) Clarad L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1945, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12, 1945 to Dec. 15, 1945 and that I last saw him alive on Dec. 15, 1945

Immediate cause of death	DURATION
Passive Pulmonary Congestion	3 Mos.
Due to: Oedema of Lungs	2 Mos.
Due to: Myocarditis	15 yrs. (Estimated)
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: /

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harry L. Dodd, M.D.

M. D. or other

Address: Chestertown, Md. Date signed Dec. 18, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12447

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred: Spring Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Spring Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ida Simmons

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21 1865

8. AGE: Years: 80 Months: 4 Days: 29 If less than one day: hrs. min.

9. Birthplace: New London, Pa.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Home

FATHER
12. Name: (Lab) George Simmons
13. Birthplace: Cecil Co. Md.

MOTHER
14. Maiden name: Mary Burge Simmons
15. Birthplace: Delaware

16. Informant: Mrs. Anna Gehr Simmons
Address: Chestertown Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/22/45 (month) (day) (year)
Cemetery or crematory: Newark
Location: Newark, Delaware

18. Funeral director: Marvin H. Williams
Address: Chestertown, Maryland

19. Dec. 22, 1945 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 1945, at 3:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1945, to Dec. 20, 1945
and that I last saw her alive on Dec. 19, 1945

Immediate cause of death	DURATION
Cardiac Paresis, Toxemia	
Asthenia, Pulmonary Oedema	4 days.
Due to: Lobar Pneumonia.	33 days.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry L. Dodd, M.D. M. D. or other
Address: Chestertown, Maryland Date signed: Dec. 24, 1945.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

12448

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Worton P.D. #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Worton P.D. #1

(If outside city or town limits, write RURAL and give nearest town)

Street No.: - Butlerton -

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Harrison M. Silghman

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C	Maried

6.(b) Name of husband or wife: Mary E. Silghman

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): February 12, 1872

8. AGE: Years: 73 | Months: 9 | Days: 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Worton Kent Co. Maryland.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm.

FATHER — 12. Name: Nathaniel Silghman

FATHER — 13. Birthplace: Worton, Kent Co. Md.

MOTHER — 14. Maiden name: Sarah Eliz. Sumner

MOTHER — 15. Birthplace: Fairlee, Kent Co. Maryland.

16. Informant: Mr. Isaiah Silghman

Address: 1613 Madison Ave. Balto - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/45 (month) (day) (year)

Cemetery or crematory: Butlerton

Location: (Near) Worton Kent Co. Md.

18. Funeral director: Harris J. Williams

Address: Chestertown Maryland.

19. Dec. 9, 1945 (Date rec'd by registrar) Clara L. Burns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1945 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1945, to Dec 5 1945, and that I last saw h... alive on Dec 3 1945

Immediate cause of death	DURATION
chron Endo-Myocarditis	
decompensation	
Due to: Hypertension	
chron Nephritis	
Due to: Uremia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed 12/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B3-6)

CERTIFICATE OF DEATH

12443

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Elizabeth Emily VanZant

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Louis H. VanZant
Deceased 6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) March 24 - 1866

8. AGE: Years	Months	Days	If less than one day
79	9	6	..... hrs. ..... min.

9. Birthplace Helena Kent Co Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER 12. Name	John Henry Jones
FATHER 13. Birthplace	Kent Co Md
MOTHER 14. Maiden name	Susan Emeline Symington
MOTHER 15. Birthplace	Kent Co Md

16. Informant Mrs Lena VanZant
Address Chestertown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-2-1946 (month) (day) (year)
Cemetery or crematory Chester Cemetery
Location Chestertown, Maryland
18. Funeral director J. Willis Heck
Address Chestertown Maryland
19. Jan. 1 1946 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1945 at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18 1945 to Dec. 19 1945
and that I last saw h[illegible] alive on Dec 19 1945

	DURATION
Immediate cause of death Cerebral Embolism	2 days
Due to Arteriosclerosis	1 year
Due to	
Other conditions Hypertrophic Hemiplegia not Incidental to Pregnancy	Aug 18

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank W Truitt M. D. or other
Address Chestertown Date signed 12/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12450

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:
County Kent
City or town Near Kennedyville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? whole life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Rural Kennedyville md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war Near Kennedyville md

3.(a) FULL NAME Edwin P. Wallis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1877

8. AGE: Years 68 | Months | Days 20 | If less than one day hrs. min.

9. Birthplace Kent Co (Town, county, and state)
10. Usual occupation Farming
11. Industry or business Farmer
FATHER 12. Name Colburn L Wallis
13. Birthplace Kent Co
MOTHER 14. Maiden name Annie L Hurlock
15. Birthplace Kent Co
16. Informant Robert Wallis
Address Rural Kennedyville
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 27 1945 (month) (day) (year)
Cemetery or crematory Sabrewsbury
Location Near Kennedyville Md.
18. Funeral director B R Fellows
Address Still Pond md
19. 12/27 1945 (Date rec'd by registrar) J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1945, at 5 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
No Medical attendance	
Due to Found dead in bed	
Due to Endeavoring to entrude heart failure	
Other conditions Kidney - short of breath last year	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Refused
Means of injury Injured at work Refused Directing

23. SIGNATURE Franklin Lewis M. D. or Coroner
Address Chestertown Md Date signed 12/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of the age of the deceased is shown on FILM No. I 00 JAN 8 1946

Mr. Smith

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

12451

Reg. Diat. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 Queen St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Eissie Marie Wilson

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Married

6.(b) Name of husband or wife: Charles Wilson

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 30 1901

8. AGE:

Years	Months	Days	If less than one day
44 43	6	16	...hrs. ...min.

9. Birthplace: Fairlee Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: John Bailey

FATHER 13. Birthplace: Kent Co. Maryland

MOTHER 14. Maiden name: Alburtta Hanis

MOTHER 15. Birthplace: Kent Co. Maryland

16. Informant: Mrs. Sarah Simmons (Sister)

Address: 352 Prospect Ave Willow Grove, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/20/45 (month) (day) (year)

Cemetery or crematory: Fairlee

Location: Fairlee Kent Co. Maryland

18. Funeral director: Marvin C. Williams

Address: Chestertown Maryland.

19. Dec. 18, 1945 (Date rec'd by registrar) Clara L. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1945, at 5:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1945 to Dec 16 1945 and that I last saw h[illegible] alive on Dec 16 1945

	DURATION
Immediate cause of death: Cirrhosis of Liver	6 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Frankel Smith M. D. or other

Address: [illegible] Date signed 12/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Call Sun papers.

Wednesday - 1 ?/M.
Sent from Home
Interment Principio Furnace.
Rev. Paul E. Reynolds.

Blanc: